TEXAS DEPARTMENT OF HEALTH
THIRD TRIMESTER INDUCED ABORTION CERTIFICATION FORM

CERTIFICATION FORM NOT REQUIRED IF BIPARIETAL DIAMETER OF FETUS IS LESS THAN 60 MILLIMETERS.

Name of physician performing the procedure: _____

Texas License Number: _____

Information on facility where procedure was performed:

Name _____

Address _____

Telephone Number _____

Date of Procedure: _____ Gestational Age: _____ Type of Procedure: _____

Patient's Name: _____
Last First Middle

Patient's Date of Birth: _____

ATTACH ADDITIONAL SHEET(S) EXPLAINING INFORMATION USED TO ESTABLISH LENGTH OF PREGNANCY.

Place a check beside the medical indications supporting the physician's judgment that the abortion was authorized by Texas Health and Safety Code, §170.002(b)(2) or §170.002(b)(3), (listed below):

____ the abortion is necessary to prevent the death or a substantial risk of serious impairment to the physical or mental health of the woman - §170.002(b)(2)

____ the fetus has a severe and irreversible abnormality, as identified through reliable diagnostic procedures - §170.002(b)(3)

_____ _____
Physician's Signature Date

_____
Physician's Printed Name

§170.002(c) of the Texas Health and Safety Code requires a physician who performs an abortion during the third trimester of the pregnancy to make a written certification to the Texas Department of Health on a form prescribed by the department on or before the 30th day after the date the abortion was performed. Please mail this completed form to the following:

Statistical Services Division
PO Box 4124
Austin TX 78765-4124

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